FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045336

Facility Name: Paris Health Care Center

Address: 1011 North Main Street (Number) Paris (City) 61944 (Zip Code)

County: Edgar

Telephone Number: (217) 465-5376 **Fax #** (217) 465-8106

IDPA ID Number: 38-3592165001

Date of Initial License for Current Owners: 04/19/2001

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Murphy BKD, LLP **Telephone Number:** (918) 584-2900

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/19/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) R. Lee Crabill, Omega Healthcare Investors, Inc.

(Title) Senior Vice President Nursing Home Operations

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Christopher Murphy, Senior Manager

(Firm Name & Address) BKD, LLP, 1 West Third Street, Suite 1700, Tulsa, Oklahoma 74103

(Telephone) (918) 584-2900 Fax # (918) 584-2931

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	5,140	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	108	Intermediate (ICF)	108	27,756	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	128	TOTALS	128	32,896	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	0	1,020	1,020	8
9	SNF/PED	0	0	0		9
10	ICF	19,515	6,543	16	26,074	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	19,515	6,543	1,036	27,094	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.36%

D. How many bed-hold days during this year were paid by Public Aid?
138 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/19/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/19/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,020

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	111,707	13,420	6,308	131,435		131,435		131,435			1
2	Food Purchase		103,261		103,261		103,261		103,261			2
3	Housekeeping	53,409	6,092	275	59,776		59,776		59,776			3
4	Laundry	23,842	8,256		32,098		32,098		32,098			4
5	Heat and Other Utilities			100,376	100,376		100,376		100,376			5
6	Maintenance	20,791	1,494	41,951	64,236		64,236		64,236			6
7	Other (specify):* Infectious waste remo			714	714		714		714			7
8	**TOTAL General Services**	209,749	132,523	149,624	491,896		491,896		491,896			8
	B. Health Care and Programs											
9	Medical Director			5,312	5,312		5,312		5,312			9
10	Nursing and Medical Records	890,979	57,171	1,551	949,701		949,701		949,701			10
10a	Therapy			57,769	57,769		57,769		57,769			10a
11	Activities	19,095	966	1,096	21,157		21,157		21,157			11
12	Social Services	22,314		830	23,144		23,144		23,144			12
13	Nurse Aide Training	6,827		3	6,830		6,830		6,830			13
14	Program Transportation			1,528	1,528		1,528		1,528			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	939,215	58,137	68,089	1,065,441		1,065,441		1,065,441			16
	C. General Administration											
17	Administrative	36,264			36,264		36,264		36,264			17
18	Directors Fees											18
19	Professional Services			195,712	195,712		195,712		195,712			19
20	Dues, Fees, Subscriptions & Promotions			9,125	9,125	1,411	10,536		10,536			20
21	Clerical & General Office Expenses	44,165	15,414	18,301	77,880		77,880		77,880			21
22	Employee Benefits & Payroll Taxes			233,932	233,932	(1,411)	232,521		232,521			22
23	Inservice Training & Education			6,679	6,679		6,679		6,679			23
24	Travel and Seminar			15,663	15,663		15,663		15,663			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			194,403	194,403		194,403		194,403			26
27	Other (specify):*											27
28	**TOTAL General Administration**	80,429	15,414	673,815	769,658		769,658		769,658			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,229,393	206,074	891,528	2,326,995		2,326,995		2,326,995			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Paris Health Care Center #0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			3,555	3,555		3,555		3,555			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			44,320	44,320		44,320		44,320			33
34	Rent-Facility & Grounds			367,397	367,397		367,397	(218,215)	149,182			34
35	Rent-Equipment & Vehicles			288	288		288		288			35
36	Other (specify):*											36
37	**TOTAL Ownership**			415,560	415,560		415,560	(218,215)	197,345			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,732	2,060	24,792		24,792		24,792			39
40	Barber and Beauty Shops		597		597		597		597			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,790	53,790		53,790		53,790			42
43	Other (specify):* **Lab & Rad**		102	955	1,057		1,057		1,057			43
44	**TOTAL Special Cost Centers**		23,431	56,805	80,236		80,236		80,236			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,229,393	229,505	1,363,893	2,822,791		2,822,791	(218,215)	2,604,576			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$ #VALUE!	#####	$	1
2	Other Care for Outpatients	#VALUE!	#####		2
3	Governmental Sponsored Special Programs	#VALUE!	#####		3
4	Non-Patient Meals	#VALUE!	#####		4
5	Telephone, TV & Radio in Resident Rooms	#VALUE!	#####		5
6	Rented Facility Space	#VALUE!	#####		6
7	Sale of Supplies to Non-Patients	#VALUE!	#####		7
8	Laundry for Non-Patients	#VALUE!	#####		8
9	Non-Straightline Depreciation	#VALUE!	#####		9
10	Interest and Other Investment Income	#VALUE!	#####		10
11	Discounts, Allowances, Rebates & Refunds	#VALUE!	#####		11
12	Non-Working Officer's or Owner's Salary	#VALUE!	#####		12
13	Sales Tax	#VALUE!	#####		13
14	Non-Care Related Interest	#VALUE!	#####		14
15	Non-Care Related Owner's Transactions	#VALUE!	#####		15
16	Personal Expenses (Including Transportation)	#VALUE!	#####		16
17	Non-Care Related Fees	#VALUE!	#####		17
18	Fines and Penalties	#VALUE!	#####		18
19	Entertainment	#VALUE!	#####		19
20	Contributions	#VALUE!	#####		20
21	Owner or Key-Man Insurance	#VALUE!	#####		21
22	Special Legal Fees & Legal Retainers	#VALUE!	#####		22
23	Malpractice Insurance for Individuals	#VALUE!	#####		23
24	Bad Debt	#VALUE!	#####		24
25	Fund Raising, Advertising and Promotional	#VALUE!	#####		25
26	Income Taxes and Illinois Personal Property Replacement Tax	#VALUE!	#####		26
27	Nurse Aide Training for Non-Employees	#VALUE!	#####		27
28	Yellow Page Advertising	#VALUE!	#####		28
29	Other-Attach Schedule	#VALUE!	#####		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ #VALUE!		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$ #VALUE!	######	31
32	Donated Goods-Attach Schedule*	#VALUE!	######	32
33	Amortization of Organization & Pre-Operating Expense	#VALUE!	######	33
34	Adjustments for Related Organization Costs (Schedule VII)	#VALUE!	######	34
35	Other- Attach Schedule	#VALUE!	######	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ #VALUE!		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ #VALUE!		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Paris Health Care Center

ID#

Report Period Beginning: 04/19/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	#VALUE!	$ #VALUE!	#VALUE!	1
2	#VALUE!	#VALUE!	#VALUE!	2
3	#VALUE!	#VALUE!	#VALUE!	3
4	#VALUE!	#VALUE!	#VALUE!	4
5	#VALUE!	#VALUE!	#VALUE!	5
6	#VALUE!	#VALUE!	#VALUE!	6
7	#VALUE!	#VALUE!	#VALUE!	7
8	#VALUE!	#VALUE!	#VALUE!	8
9	#VALUE!	#VALUE!	#VALUE!	9
10	#VALUE!	#VALUE!	#VALUE!	10
11	#VALUE!	#VALUE!	#VALUE!	11
12	#VALUE!	#VALUE!	#VALUE!	12
13	#VALUE!	#VALUE!	#VALUE!	13
14	#VALUE!	#VALUE!	#VALUE!	14
15	#VALUE!	#VALUE!	#VALUE!	15
16	#VALUE!	#VALUE!	#VALUE!	16
17	#VALUE!	#VALUE!	#VALUE!	17
18	#VALUE!	#VALUE!	#VALUE!	18
19	#VALUE!	#VALUE!	#VALUE!	19
20	#VALUE!	#VALUE!	#VALUE!	20
21	#VALUE!	#VALUE!	#VALUE!	21
22	#VALUE!	#VALUE!	#VALUE!	22
23	#VALUE!	#VALUE!	#VALUE!	23
24	#VALUE!	#VALUE!	#VALUE!	24
25	#VALUE!	#VALUE!	#VALUE!	25
26				26
27	#VALUE!	#VALUE!	#VALUE!	27
28	#VALUE!	#VALUE!	#VALUE!	28
29	#VALUE!	#VALUE!	#VALUE!	29
30	#VALUE!	#VALUE!	#VALUE!	30
31	#VALUE!	#VALUE!	#VALUE!	31
32	#VALUE!	#VALUE!	#VALUE!	32
33				33
34	#VALUE!	#VALUE!	#VALUE!	34
35				35
36	#VALUE!	#VALUE!	#VALUE!	36
37	#VALUE!	#VALUE!	#VALUE!	37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47	#VALUE!	#VALUE!	#VALUE!	47
48				48
49	**Total**	#VALUE!		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Paris Health Care Center **#** 0045336 **Report Period Beginning:** 04/19/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Paris Health Care Center # 0045336 **Report Period Beginning:** 04/19/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(218,215)	0	0	0	0	0	0	0	0	0	(218,215)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(218,215)	0	0	0	0	0	0	0	0	0	(218,215)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(218,215)	0	0	0	0	0	0	0	0	0	(218,215)	45

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Omega Healthcare Investors, Inc.	100.00	Skilled Nursing Herrin, Inc. d/b/a Park Avenue Healthcare Center	Herrin			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Lease	$ 367,397	Omega Healthcare Investors, Inc.	100.00%	$ 149,182	$ (218,215)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 367,397			$ 149,182	$ * (218,215)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Skilled Nursing Paris, Inc. # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$		-	$	1
2										-		2
3										-		3
4										-		4
5												5
	Working Capital											
6	Owner	X		Working Capital	None	N/A	842,657	842,657	N/A	None	N/A	6
7												7
8												8
9	TOTAL Facility Related						$ 842,657	$ 842,657			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 842,657	$ 842,657			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	27,583	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	39,192	2
3. Under or (over) accrual (line 2 minus line 1).	$	11,609	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	32,711	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	44,320	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	13,459	8
	1997	13,797	9
	1998	28,445	10
	1999	27,583	11
	2000	27,583	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Paris Health Care Center COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0045336

CONTACT PERSON REGARDING THIS REPORT Christopher Murphy BKD, LLP

TELEPHONE (918) 584-2900 FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-13-36-100-0210	Nursing Facility	$ 64,180.10	$ 64,180.10
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 64,180.10	$ 64,180.10

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,377 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	85		1982		$ Rent Related	$		$	$	$	4
5	43				Party 7/1/99						5
6											6
7											7
8											8
	Improvement Type**										
9	Down payment - Floor covering carpet			2001	1,296	108	5	108		108	9
10	Final payment - Floor covering carpet			2001	5,183	346	5	346		346	10
11	Asbestos removal			2001	62,575	261	20	261		261	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$	-	$	$	$	37
38					-				38
39					-				39
40					-				40
41					-				41
42					-				42
43					-				43
44					-				44
45					-				45
46					-				46
47					-				47
48					-				48
49					-				49
50					-				50
51					-				51
52					-				52
53					-				53
54					-				54
55					-				55
56					-				56
57					-				57
58					-				58
59					-				59
60					-				60
61					-				61
62					-				62
63	(DON'T ENTER BELOW THIS LINE)								63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 69,054	$ 715		$ 715	$	$ 715	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	42,978	2,840	2,840		Various	2,840	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 42,978	$ 2,840	$ 2,840	$		$ 2,840	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 112,032	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 3,555	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 3,555	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,555	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - leased from related party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 288 Description: Nursing - 210, Maintenance - 78
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				6,827
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$ 6,827
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	20
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	19
2. From other facilities (f)	
TOTAL TRAINED	39

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	-	$ 11,876	$ -		$ 11,876	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		-	1,744	-		1,744	2
3	Licensed Recreational Therapist		hrs		-	-	-			3
4	Licensed Physical Therapist	10a, 3	hrs		-	44,148	-		44,148	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10, 3	# of prescrpts		Monthly Fee	255	-		255	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 58,023	$		$ 58,023	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (2,851)	$	1
2	Cash-Patient Deposits	201		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,014,239		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	55,301		7
8	Accounts Receivable (owners or related parties)	81,237		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,148,127	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	69,054		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	42,978		16
17	Accumulated Depreciation (book methods)	(3,555)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 108,477	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,256,604	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 482,456	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(6,697)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,995		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,219		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,711		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Management Fee Payable	3,187		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 645,871	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	842,657		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Payable	(80,281)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 762,376	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,408,247	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (151,643)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,256,604	$	48

***(See instructions.)**

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(151,643)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (151,643)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (151,643)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,095,689	1
2	Discounts and Allowances for all Levels	(669,902)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,425,787	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,572	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 130,572	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31,797	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,814	19
20	Radiology and X-Ray		20
21	Other Medical Services	77,879	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 113,490	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	1,299	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,299	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,671,148	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	491,896	31
32	Health Care	1,065,441	32
33	General Administration	769,658	33
	B. Capital Expense		
34	Ownership	415,560	34
	C. Ancillary Expense		
35	Special Cost Centers	26,446	35
36	Provider Participation Fee	53,790	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,822,791	40
41	**Income before Income Taxes (line 30 minus line 40)****	(151,643)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (151,643)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,723	6,908	144,247	20.88	3
4	Licensed Practical Nurses	19,109	19,109	303,944	15.91	4
5	Nurse Aides & Orderlies	49,681	52,838	449,616	8.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,524	1,524	9,422	6.18	9
10	Activity Assistants	1,337	1,422	9,673	6.80	10
11	Social Service Workers	1,976	2,059	22,314	10.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,532	13,924	111,707	8.02	15
16	Dishwashers					16
17	Maintenance Workers	2,102	2,194	20,791	9.48	17
18	Housekeepers	8,176	8,504	53,409	6.28	18
19	Laundry	3,994	4,120	23,842	5.79	19
20	Administrator	1,425	1,425	36,264	25.45	20
21	Assistant Administrator					21
22	Other Administrative	4,137	4,339	36,931	8.51	22
23	Office Manager					23
24	Clerical	411	437	7,233	16.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,127	118,802	$ 1,229,393 *	$ 10.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	173	$ 6,308	1, 3	35
36	Medical Director	Monthly Fee	5,312	9, 3	36
37	Medical Records Consultant	8	243	10, 3	37
38	Nurse Consultant	2	42	10, 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,096	11, 3	44
45	Social Service Consultant	17	830	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	221	$ 13,831		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	24	1,002	10, 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	24	$ 1,002		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bob Mattox	Admin.	0%	$ 36,264
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 36,264

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Professional Svs. Admin	$ 7,287
See Attached	Legal Fees	36,435
ADP	Payroll Process	7,789
Virtual Care Provider, Inc.	ASP Fees	9,972
Nexion Health, Inc.	Mgmt Fees	134,229
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 195,712

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,075
Unemployment Compensation Insurance	33,024
FICA Taxes	93,940
Employee Health Insurance	36,292
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	1,911
Moving Expenses	3,056
Mgmt Fee Benefit	(1,411)
Vacation Reserve	26,634
TOTAL (agree to Schedule V, line 22, col.8)	$ 232,521

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,411
(Indicate # of checks performed 73)	
Dues & Subscriptions	7,499
Advertising & Public Relations	1,626
Other AR Lending Fees	
Less: Public Relations Expense	
Non-allowable advertising	#VALUE!
Yellow page advertising	#VALUE!
TOTAL (agree to Sch. V, line 20, col. 8)	$ #VALUE!

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,139
In-State Travel	10,769
Seminar Expense	523
Meals & Entertainment	1,232
Less: Entertainment Expense	#VALUE!
TOTAL (agree to Sch. V, line 24, col. 8)	$ #VALUE!

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 04/19/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **5983 - Illinois Health Care Assoc.**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **10,829** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **53,790**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **None**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes** **airline exp for**
If YES, attach a complete explanation. **out-of-state seminars, see pg 21 sect G.**
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.